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ABSTRACT

The problems of doing family therapy in any mental health setting are well-known. Trying to get a program of family therapy established in a state hospital has its own share of problems. But it also has its payoffs. This presentation describes the establishment of a family therapy program in one state hospital, highlighting the problems and payoffs of the program. An historical approach is taken, recounting the stages of the program's development. Some general issues are then considered. (Author)

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Family Therapy in a State Hospital: Problems, Pitfalls and Possibilities[1]

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The problems of doing family therapy in any mental health setting are well-known. Trying to get a program of family therapy established in a state hospital has its own share of problems. But, it also has its payoffs. The purpose of this presentation is to describe the establishment of a family therapy program in one state hospital, highlighting the problems encountered, the payoffs of the program, etc. An historical approach recounting the stages of the program's development will be taken. Some issues will then be considered.

Background: Dixmont State Hospital is a small state hospital serving approximately 425 patients from two counties in western Pennsylvania. Life in these two counties centers largely around the steel mills, although there is also a fairly large rural population. Persons living here tend to be lower middle class, coming from a wide range of ethnic backgrounds, having usually no more than a high-school education. It is striking how few people leave this area. With little exception, persons usually spend all their lives here. It is not uncommon to see two or three generations of the same family who have lived in this area all of their lives.

Dixmont prides itself on providing a high level of patient care. About ten years ago, considerable effort by the current

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superintendent went into returning as many patients to the community as possible. The patients now remaining, who make up the largest numberof Dixmont patients, are either geriatric or chronic, or both. A large percentage of patients are over 65 and have been at Dixmont most, if not all, of their adult lives. With very rare exception, there are no patients at Dixmont under the age of 21.

Stage #1 (Pre-Family Therapy Discussion Group): For many years family members have been included in the treatment of Dixmont patients. This was done largely by social workers within a social casework framework. Here the problem continued to be defined as the problem of the identified patient (IP). Other family members were included in order to facilitate the treatment of the IP. But, the emphasis was still on changing the IP rather than on changing the family. Other hospital staff (psychiatrists, psychologists, vocational counselors, etc.) have also had contact with other family members through the years. But, here too, other family members were included within an individual therapy framework.

Working with families where the focus was on changing the family and not just the IP did not begin at Dixmont until 1972. This happened when it became clear that an individual approach to treatment just wasn't enough. It became increasingly obvious to everyone working with certain patients that there were issues involving other family members which greatly influenced his/her behavior. For example, problems would inevitably arise when the IP would go on a home visit or be furloughed. Although his/her situation had been stabilized in the hospital, as soon as s/he

got home, problems would flare up again and s/he would end up right back in the hospital. This led to involving the whole family in the therapy process.

This initial work with families was done on two wards by three psychologists and one social worker. About the same time, several hospital staff (including one of the above psychologists, a nurse and a social worker) were involved in an intensive program of family therapy training at a local teaching institute. They were seeing families in the community, but with the one exception were not seeing Dixmont families.

Others interested in family therapy at this time included a social worker involved outside the hospital in work primarily with couples, the new-to-Dixmont and soon-to-be appointed director of social service who had been involved in family therapy programs elsewhere, and a rather large number of other staff from a range of hospital disciplines who thought the idea of seeing families made sense, although they didn't know much about it.

A proposal to institute a Family Therapy Treatment Service was introduced in April, 1973. After considerable revision and much delay, a proposal for a Family Therapy Discussion Group (FTDG) was approved by the hospital superintendent and an open meeting for anyone interested in family therapy was called for December 3, 1973.

The superintendent chaired this first meeting of the FTDG. It was attended by about 20 persons, from all hospital disciplines, including most of the persons previously mentioned as being interested in family therapy. The interdisciplinary nature of the group was emphasized, as well as the superintendent's support for

and interest in the FTDG.

Stage #2 (Pre-Consultant Period): This was the six-months between this first open meeting and the time when an outside consultant in family therapy first joined the group June 3, 1974. There were about 20 persons from all disciplines who regularly attended the weekly meetings. The average number of persons at any one meeting was 10-12. From the beginning, there was a lack of group direction. It was never quite clear what the purpose of the FTDG was. Two conflicting views as to what this should be emerged. This division of views has remained to the present.

The first view was that the purpose was to get family therapy done at Dixmont. The persons voicing this view were largely those already seeing Dixmont Families. They were concerned with getting more Dixmont families seen and getting more staff involved in seeing Dixmont families. There were periodic appeals from one person (who was most involved in seeing families) to get others from the entire group involved. However, the staff working with Dixmont families during this time were still those previously involved.

Although somewhat less explicit, the second view was that the FTDG was a forum to learn more about family therapy, and didn't necessarily involve seeing Dixmont families. Persons here could perhaps see themselves doing family therapy at sometime in the future, but were hesitant to get involved now with Dixmont families.

During this stage, there was growing interest in having outside consultation and expertise. This was probably in response to the lack of group direction. Eventually, this led to the superintendent requesting regular consultation for the FTDG from the local teaching institute.

Stage #3 (First Consultant Period): This stage lasted from June 3, 1974 until December 16, 1974. The conflict of views continued during this time, the first group wanting the focus to be on actual cases, the second group wanting the focus to be on experiential exercises related to working with families.

Initially, there were bi-weekly meetings with the consultant on experiential exercises such as family sculpting, family drawings, family photographs, etc. The consultant requested that every other consultation be a case conference, and that every group member was to see a family. Neither of these requests worked out. Eventually, the group decided to meet bi-monthly only when the consultant was there. The consultant agreed to meet with individuals about cases.

The attendance at meetings declined sharply during this time. Those attending tended to be just those in the learning about family therapy group. Those interested in getting family therapy done met with the consultant just about cases. Those who had been seeing Dixmont families all along were still essentially the only ones involved in doing family therapy.

The first consultant announced she would be unavailable after January 1, 1975. The group decided it still wanted outside consultation, and was able to obtain the services of a second consultant from the same teaching institute.

Stage #4 (Second Consultant Period): This period lasted from January, 1975 until July, 1975. Attendance varied, but was generally higher than during Stage #3. There was a reorganization meeting which took place in January, 1975. Shortly after, the group met with the second consultant. She made a strong pitch for

seeing families as being the only way one can really learn about family therapy.

This had little effects on getting others to see Dixmont families. Those who had been seeing Dixmont families with little exception continued to be the only ones involved in doing family therapy.

Most of the group's activities during this period focused on trips to the teaching institute to meet with the consultant and view videotapes of work with families being seen there.

Attending meetings during this period were those doing family therapy and those interested only in learning about family therapy. Those doing family therapy also met with this consultant for case consultation.

The services of the second consultant were lost when Dixmont was no longer able to obtain consultation from the teaching institute without paying for it.

Stage #5 (Family Therapy Program Period): In September 1975 the newly appointed Assistant Superintendent for Clinical Services announced the formation of the Family Therapy Program (FTP), to formalize family therapy as one treatment alternative at Dixmont. He appointed one of the psychologists involved in seeing Dixmont families as coordinator of the FTP.

The initial meetings of the FTP were sparsely attended. They focused on the continuing conflict as to what the purpose of the group should be. With considerable ambivalence, the coordinator decided to focus on doing family therapy. Participation in the FTP required staff to see a Dixmont family within two months of joining the group.

The goals of the FTP were to continue getting more Dixmont families seen, and on getting more staff seing families. The first goal is being realized, but the second is not. The co-ordinator is essentially the only one currently seeing Dixmont families. (Of the other original four, one has left Dixmont, one is on leave of absence and one is no longer interested). The approach being used to involve more staff is to invite them to see families with the coordinator. Another plan to stimulate involvement is to offer a family therapy course to hospital staff.

There are weekly meetings of the FTP. They continue to be sparesely attended. These are problem-oriented meetings, focusing on work currently being done with Dixmont families. Different approaches to doing family therapy are also considered in this context.

Some Issues to be Considered: Probably the most striking thing is how difficult it has been to get more staff involved in seeing Dixmont families. Although there have been 25-30 different persons involved in the FTDG at one time or another, the only ones actually seeing Dixmont families have been those involved from the very beginning. Many other staff have seen a family or two, but haven't become actively involved.

The reasons for this lack of involvement are many, and vary with the individual. Probably the central issue has to do with the attitude of most hospital staff that not much can be done psychotherapeutically for most Dixmont patients, anyway. The best that can be done is to provide patients with good nursing care, treat them as humanely as possible, teach them self-care

skills, etc. All of this is done at Dixmont. Whether or not psychotherapy can be done, the attitude that it cannot prevails. And, Dixmont is probably not much different from most other state hospitals in this respect. But, it is particularly easy for this attitude to be promulgated at Dixmont, with its largely geriatric and chronic population.

One specific example of this was the feeling that there just are no families to be seen at Dixmont. This attitude was particularly apparent in the first year or two of doing family therapy here. The fact that over 40 families have been seen in the past three years, many with striking success, has tended to quiet this objection.

Another thing is that the job of providing psychotherapy at Dixmont has historically fallen to psychologists. They have had the most flexibility in what is required of them. Psychiatrists function largely as ward administrators, having little time for patient contact. Those in other disciplines have specific job responsibilities, making it difficult for them to find the time to get involved. Cutbacks in funds and the loss of staff positions have complicated this even more. Therefore, it isn't surprising that psychologists are largely the ones who have seen Dixmont families in a family therapy context.

Related to this is the logistics problems of seeing Dixmont families. It has often been necessary to see families at other than the usual working hours. This has meant being here in the evening or on weekends. It has also been necessary to drive to the homes of some families. This often involves being away from

the hospital for several hours. This has discouraged or prevented interested staff from seeing families.

There always has been at least tacit approval for doing family therapy at Dixmont. More recently, there has been formal approval. However, there has also been some informal disapproval. What was originally approved was a family therapy <u>discussion</u> group, not a family therapy <u>treatment</u> service. What was officially sanctioned, then, was not the doing of family therapy, but the discussion of family therapy. This has changed with the institution of the FTP.

Too, some staff have felt that family therapy was already being done by some as a regular part of their job. So, involving other disciplines in seeing families would mean duplicating this. Further, it would tend to blur discipline boundaries. So, politically it has been difficult for some to see families who might otherwise be interested.

Finally, doing family therapy is a radical departure from the usual modes of treatment. As with anything new, there is resistance to change. Seeing families at Dixmont has meant getting more organized and having to work harder than one would have to doing the same old things in the same old ways. It has meant having to give more thought to what one is doing (and <u>not</u> doing), and having to unlearn much of what one has taken so many years to learn. It has meant getting more involved in the totality of the IP's life. It has often meant having to leave one's comfortable offices, venturing forth to deal with families in their own domain.

It has taken a great deal of motivation to go through all of this in order to see families. Perhaps it isn't so surprising, after all, that so few staff have become involved in seeing families!

A second issue is why so many staff were interested in family therapy and became involved in the FTDG. The results of a survey which asked this question of the FTDG participants and the two outside consultants strongly suggested that it gave most people a legitimate opportunity to get away from the demands of their every day jobs. It provided staff an opportunity to be with one's fellow employees in a setting where one could be oneself; it made one's otherwise routine job more interesting. The fact that it was a family therapy group was not particularly important, although most staff did have some interest in family therapy. In principle, the group could have been dealing with almost anything. One consultant commented that the greatest need of the persons there was to be identified as a family, to get some sense of belonging, not otherwise provided in the work setting. The other consultant noted that some were intellectually interested and some came to be amused. Others probably came out of curiosity. But only two seemed to have any interest in doing family therapy.

With all of this, what then have been the payoffs of family therapy at Dixmont? One payoff is the results that one gets doing family therapy. It works, often in situations where nothing else has worked. Probably the biggest payoff though, has been the personal sense that something one has done makes a concrete difference in the lives of those one works with. After working in

a state hospital setting for five years, it is easy to forget that this can happen!

What is the place of family therapy at Dixmont? It is here to stay, at least for the moment. It has achieved some formal status and recognition within the hospital as an alternative treatment mode. And, it will probably be possible to do family therapy as long as there is anyone interested in doing it. However, it seems quite unlikely that family therapy will be done at Dixmont once those already doing it leave the hospital. The track record in getting new staff involved is poor. It's not likely this will change much in the future.